

visualised, but the presence of D₂ receptors is controversial, with the six or so studies being evenly divided. The most recent work suggests that they are present, but in much smaller numbers than D₁ receptors. In these circumstances, it seems unwarranted to dismiss the existence of a dopamine innervation of these regions.

The strengths and weaknesses of the dopamine hypothesis have been frequently rehearsed, most recently by Crow (1987). Briefly, its most serious drawbacks are the long time-course of the neuroleptic effect, its incompleteness in many patients, and perhaps also the relative lack of psychotogenic activity of direct dopamine agonists. These, though, must be balanced against the powerful, unrefuted circumstantial evidence implicating dopamine in psychotic and antipsychotic drug actions. *In vivo* receptor binding studies have the potential to test the dopamine hypothesis directly. The first such study on drug-naïve schizophrenic patients was positive. The second (Farde *et al.*, 1987) (which has not yet been reported in full) gave overall negative results. Even so, 10–30% increases in dopamine receptors were observed on the left side in 4 of the 15 schizophrenics, but in none of the controls (Farde *et al.*, 1987).

Finally, it is possible, as Dr Kerwin suggests, to conceptualise schizophrenia as a collection of heterogeneous disorders. Clinically, however, none of the attempts to overthrow Kraepelin in this way have met with wide acceptance. Aetiologically, it may well be that schizophrenia will ultimately fragment into more than one disease entity (cf. Murray *et al.*, 1985). Nevertheless, it is arguable that this will not invalidate the unitary pathogenetic basis of the core phenomenological syndrome.

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Behavioural Psychotherapy in General Practice – A Response

SIR: It is a little surprising, if I follow Professor Beech's reasoning correctly (*Journal*, September 1987, **151**, 411), that despite the paucity of knowledge and experience that he feels are required by psychiatrists, some psychologists in private practice or as authors of texts (Beech *et al.*, 1982), or even within the NHS, should wish to use the title 'consultant' or 'doctor' (the latter legitimately from possession of a PhD, but both potentially misleading in the NHS) – as this is presumably partly with the idea (Anon, 1983) of attracting that indefinable, but desirable, aura (probably with quite primitive roots) which surrounds their medically qualified psychiatric colleagues.

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Heroin Abuse in India

SIR: Fraser *et al.* (*Journal*, August 1987, **151**, 254–256) report on heroin abusers admitted to an acute psychiatric unit in Glasgow, and raise doubts about the value of hospital admission in the management of abusers. We had a somewhat similar experience with heroin abusers in New Delhi (Adityanjee *et al.*, 1984) in the early 1980s.

Heroin abuse, which was conspicuous by its absence in all Indian epidemiological surveys on substance abuse carried out prior to 1980, made a dramatic and sudden appearance in the metropolitan cities of India (Saxena & Mohan, 1984). There were no cases of heroin abuse registered with the de-addiction clinic of AIIMS hospital, New Delhi, prior to 1980. Between January 1981 and May 1984 a total of 105 heroin abusers were registered with the de-addiction services. All the patients except one were males. Three-quarters of abusers were in the age group 21–30 years. More than two-thirds were unmarried. A little less than one-third were unemployed at the time of contact with de-addiction services. The duration of abuse was less than one year